MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address RS Medical PO Box 872650 Vancouver WA 98687-2650	MDR Tracking No.: M4-03-7115-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 2 Universal Underwriters Ins. 363 N. Sam Houston PKWY E. #820 Houston TX 77060	Date of Injury: Employer's Name: Master Autobody Services Insurance Carrier's No.: 23317230

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
8/6/02	**8/6/02**	**E1399 RR**	**$1995.00**	**$1995.00**

PART III: REQUESTOR'S POSITION SUMMARY

"All relative documentation was submitted with initial request." RX date: 5/30/02 Richard N. Gray, MD. For: "interferential & muscle stimulator & monitoring."

PART IV: RESPONDENT'S POSITION SUMMARY

No Response received by TWCC in reference to this file.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This DME was preauthorized, therefore this is an incorrect denial code. In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 8/2/02 for the DME purchase: '4 channel interferential & muscle stimulator and monitoring.' This DME was rendered on 8/6/02. The carrier denied the durable medical equipment for 'N – Not reasonable & Necessary' medical treatment. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." This violation will be referred to Compliance and Practice. Therefore, reimbursement is recommended in the amount of $1955.00 in accordance with Rule 134.600 (b)(1)(B). Per Rule 134.202(a)(e)(5)(c)(ii) recommend reimbursement in the amount of $1,995.00.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
8/6/2002	E1399	$1,995.00	$1,995.00				
				Total Left Column:			$1,995.00
				Total Amount Due:			$1,995.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,995.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Carol Lawrence Typed Name	2 / 10 / 5 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____/ 05